

# ATTACHMENT 4

## Sample CMS 1500 claim form for chiropractic services

HEALTH INSURANCE CLAIM FORM										PICA <input type="checkbox"/>																																																																																																																																																																
<b>1. MEDICARE</b> <input type="checkbox"/> <b>MEDICAID</b> <input type="checkbox"/> <b>CHAMPUS</b> <input type="checkbox"/> <b>CHAMPVA</b> <input type="checkbox"/> <b>GROUP HEALTH PLAN (SSN or ID)</b> <input type="checkbox"/> <b>FECA BLK LUNG (SSN)</b> <input type="checkbox"/> <b>OTHER</b> <input type="checkbox"/>					<b>1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)</b> <div style="text-align: center; font-weight: bold;">1234567890</div>																																																																																																																																																																					
<b>2. PATIENT'S NAME (Last Name, First Name, Middle Initial)</b> <div style="font-weight: bold;">Recipient, Im A.</div>					<b>3. PATIENT'S BIRTH DATE</b> MM DD YY M <input type="checkbox"/> F <input checked="" type="checkbox"/>		<b>4. INSURED'S NAME (Last Name, First Name, Middle Initial)</b>																																																																																																																																																																			
<b>5. PATIENT'S ADDRESS (No., Street)</b> <div style="font-weight: bold;">609 Willow St</div>					<b>6. PATIENT RELATIONSHIP TO INSURED</b> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		<b>7. INSURED'S ADDRESS (No., Street)</b>																																																																																																																																																																			
<b>CITY</b> <div style="font-weight: bold;">Anytown</div>		<b>STATE</b> <div style="font-weight: bold;">WI</div>		<b>8. PATIENT STATUS</b> Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		<b>CITY</b>		<b>STATE</b>																																																																																																																																																																		
<b>ZIP CODE</b> <div style="font-weight: bold;">55555</div>		<b>TELEPHONE (Include Area Code)</b> <div style="font-weight: bold;">(xxx) xxx-xxxx</div>		<b>Employed</b> <input type="checkbox"/> <b>Full-Time Student</b> <input type="checkbox"/> <b>Part-Time Student</b> <input type="checkbox"/>		<b>ZIP CODE</b>		<b>TELEPHONE (INCLUDE AREA CODE)</b> <div style="font-weight: bold;">( )</div>																																																																																																																																																																		
<b>9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</b> <div style="font-weight: bold;">OI-P</div>					<b>10. IS PATIENT'S CONDITION RELATED TO:</b>					<b>11. INSURED'S POLICY GROUP OR FECA NUMBER</b>																																																																																																																																																																
<b>a. OTHER INSURED'S POLICY OR GROUP NUMBER</b>					<b>a. EMPLOYMENT? (CURRENT OR PREVIOUS)</b> <input type="checkbox"/> YES <input type="checkbox"/> NO					<b>a. INSURED'S DATE OF BIRTH</b> MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>																																																																																																																																																																
<b>b. OTHER INSURED'S DATE OF BIRTH</b> MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					<b>b. AUTO ACCIDENT?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO					<b>b. EMPLOYER'S NAME OR SCHOOL NAME</b>																																																																																																																																																																
<b>c. EMPLOYER'S NAME OR SCHOOL NAME</b>					<b>c. OTHER ACCIDENT?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO					<b>c. INSURANCE PLAN NAME OR PROGRAM NAME</b>																																																																																																																																																																
<b>d. INSURANCE PLAN NAME OR PROGRAM NAME</b>					<b>10d. RESERVED FOR LOCAL USE</b>					<b>d. IS THERE ANOTHER HEALTH BENEFIT PLAN?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>																																																																																																																																																																
<b>12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE</b> I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.  SIGNED _____ DATE _____										<b>13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE</b> I authorize payment of medical benefits to the undersigned physician or supplier for services described below.  SIGNED _____																																																																																																																																																																
<b>14. DATE OF CURRENT:</b> MM DD YY					<b>15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE</b> MM DD YY					<b>16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</b> FROM MM DD YY TO MM DD YY																																																																																																																																																																
<b>17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE</b>					<b>17a. I.D. NUMBER OF REFERRING PHYSICIAN</b>					<b>18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</b> FROM MM DD YY TO MM DD YY																																																																																																																																																																
<b>19. RESERVED FOR LOCAL USE</b>										<b>20. OUTSIDE LAB?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																																																																																																
<b>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)</b> 1. <div style="font-weight: bold;">839.20</div>										<b>22. MEDICAID RESUBMISSION CODE</b>					<b>23. PRIOR AUTHORIZATION NUMBER</b>																																																																																																																																																											
<b>24. DATE(S) OF SERVICE</b> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th colspan="3">From</th> <th colspan="3">To</th> <th>B</th> <th>C</th> <th>D</th> <th>E</th> <th colspan="2">F</th> <th>G</th> <th>H</th> <th>I</th> <th>J</th> <th>K</th> </tr> <tr> <th></th> <th>MM</th> <th>DD</th> <th>YY</th> <th>MM</th> <th>DD</th> <th>YY</th> <th>Place of Service</th> <th>Type of Service</th> <th>PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS</th> <th>MODIFIER</th> <th>DIAGNOSIS CODE</th> <th colspan="2">\$ CHARGES</th> <th>DAYS OR UNITS</th> <th>EPST Family Plan</th> <th>EMG</th> <th>COB</th> <th>RESERVED FOR LOCAL USE</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>12</td> <td>09</td> <td>03</td> <td></td> <td></td> <td></td> <td>11</td> <td></td> <td>99201</td> <td></td> <td>1</td> <td>XX</td> <td>XX</td> <td>1.0</td> <td></td> <td></td> <td></td> <td>12345678</td> </tr> <tr> <td>2</td> <td>12</td> <td>09</td> <td>03</td> <td></td> <td></td> <td></td> <td>11</td> <td></td> <td>72020</td> <td></td> <td>1</td> <td>XX</td> <td>XX</td> <td>1.0</td> <td></td> <td></td> <td></td> <td>12345678</td> </tr> <tr> <td>3</td> <td>12</td> <td>09</td> <td>03</td> <td></td> <td></td> <td></td> <td>11</td> <td></td> <td>98940</td> <td></td> <td>1</td> <td>XX</td> <td>XX</td> <td>1.0</td> <td></td> <td></td> <td></td> <td>12345678</td> </tr> <tr> <td>4</td> <td>12</td> <td>23</td> <td>03</td> <td></td> <td></td> <td></td> <td>11</td> <td></td> <td>L0500</td> <td></td> <td>1</td> <td>XXX</td> <td>XX</td> <td>1.0</td> <td></td> <td></td> <td></td> <td>12345678</td> </tr> <tr> <td>5</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>6</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>											From			To			B	C	D	E	F		G	H	I	J	K		MM	DD	YY	MM	DD	YY	Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	DIAGNOSIS CODE	\$ CHARGES		DAYS OR UNITS	EPST Family Plan	EMG	COB	RESERVED FOR LOCAL USE	1	12	09	03				11		99201		1	XX	XX	1.0				12345678	2	12	09	03				11		72020		1	XX	XX	1.0				12345678	3	12	09	03				11		98940		1	XX	XX	1.0				12345678	4	12	23	03				11		L0500		1	XXX	XX	1.0				12345678	5																			6																												
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<b>25. FEDERAL TAX I.D. NUMBER</b>					<b>26. PATIENT'S ACCOUNT NO.</b>					<b>27. ACCEPT ASSIGNMENT?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO					<b>28. TOTAL CHARGE</b> \$ XXX XX					<b>29. AMOUNT PAID</b> \$ XXX XX					<b>30. BALANCE DUE</b> \$ XX XX																																																																																																																																																	
<b>31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS</b> (I certify that the statements on the reverse apply to this bill and are made a part thereof.) <div style="font-weight: bold;">J.M. Authorized</div> MM/DD/YY										<b>32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)</b>										<b>33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE &amp; PHONE #</b> <div style="font-weight: bold;">I.M. Billing</div> <div style="font-weight: bold;">1 W. Williams</div> <div style="font-weight: bold;">Anytown, WI 55555</div> <div style="font-weight: bold;">87654321</div>																																																																																																																																																						
<b>SIGNED</b> _____ <b>DATE</b> _____										<b>PIN#</b> _____ <b>GRP#</b> _____																																																																																																																																																																

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500,  
APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)